STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 of 6 residents (Resident #1) reviewed for foot care. The facility failed to ensure Resident #1 was provided with adequate foot care and access to podiatry services. This failure could place residents at risk of discomfort, poor foot hygiene, or a decline in residents' physical condition. The findings were: Record review of the Admission Record, printed 6/04/2024, reflected Resident #1 was a [AGE] year-old female, originally admitted on [DATE]. Record review of the quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS summary score of 4, indicative of severe cognitive impairment. Resident #1's primary medical condition category that best described the primary reason for admission was coded as medically complex conditions related to a diagnosis of paranoid schizophrenia. Other active diagnoses included Huntington's Disease. Resident #1 had a clinical assessment that indicated she was at risk of developing pressure injuries. Record review of the Care Plan reflected a focus area for Resident #1 potential for pressure ulcer development, with a revision date of 7/19/2023; with the following interventions: Administer treatments as ordered; educate as to causes of skin breakdown; monitor nutritional status; obtain lab/diagnostic work as ordered. Additional focus area of ADL self-care performance deficit; with the following interventions: bathing - check nail length and trim and clean on bath day and as necessary, last revised 7/19/2023. Record review of the Order Summary Report, active as of 6/04/2024, reflected Resident #1 had orders may see podiatrist, dentist, audiologist, ophthalmologist, with a start date of 7/06/2023. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 6/06/2024 at 9:20 AM, Hospital RN A removed bilateral heel protector boots from Resident #1's feet to inspect and assess pressure injuries. Hospital RN A pointed out that Resident #1 had long curving toenails. Resident #1 had a scabbed over sore to the anterior surface of the distal end of the 2nd toe, caused by the thick and overgrown toenail of the hallux (great toe). Hospital RN A stated that all of Resident #1's toenails needed to be trimmed and filed smooth, but the hospital does not allow hospital staff to do that procedure; Resident #1 was not expected to be admitted long enough to be seen by the hospitals' podiatrist for treatment. Hospital RN A stated the length of her toenails would have grown out slowly over several months. Hospital RN A stated the scabbed over sore could have been prevented by routine foot care. In an interview on 6/05/2024 at 10:45 AM, the Family Member stated she had requested months ago for Resident #1 to be seen by the podiatrist. The family member stated that the last two times a podiatrist was in the building, Resident #1 was not seen by the podiatrist. The family member stated that Resident #1's roommate was seen the last time the podiatrist was on site, which prompted Family Member to inquire as to when Resident #1 would be seen; Family Member was told Resident #1 would not be seen that day because she was not on the list to be seen by the podiatrist. The family member stated Resident #1 was not seen the time before that when the podiatrist was in the building. The family member stated that no one at the facility could tell her when Resident #1 would be seen by a podiatrist next. In a joint interview on 6/06/2024 at 11:30 AM, the DON stated that nurses were responsible for trimming or filing residents' fingernails and toenails on a weekly basis. The DON stated he cleaned Resident #1's nails on 5/29/2024 which was the date of the last skin assessment. The DON stated he did not recall if there was anything concerning about Resident #1's fingernails or toenails. The Treatment Nurse stated she may have forgotten to document the last time she trimmed Resident #1's nails, but she recalled that, it was several months ago, and I asked the SW we had at the time to put Resident #1 on the list to be seen by podiatry. The ADON stated the previous SW was only employed for 90 days or less before she was terminated. The ADON stated Resident #1 was not placed on the list to be seen by the podiatrist at that time. The ADON stated she could find no documentation as to why this was not done. The ADON stated she could find no documentation that Resident #1 had ever been seen by a podiatrist. The ADON stated Resident #1 would be seen during the podiatrist's next visit on site. The ADON stated she was not sure of when that would be. The DON stated that the podiatrist would be next on site sometime during the month of July. The Treatment Nurse stated she was responsible for spot checking that assessments were completed timely. The Treatment Nurse stated she expected the nurses to document at the time the assessment or a treatment was done. The ADON stated the risk to residents not getting a documented skin assessment could be result in missed care or treatment. The ADON stated that if nails cause skin breakdown there was a risk for infection or pain to the resident. Record review of policy Foot Care, revised October 2022, reflected the following: 4. Trained staff may provide routine foot care (e.g., toenail clipping) for residents without complicating disease process; 5. Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals.